THE FOLLOWING DOCUMENTS ARE NEEDED EITHER PRIOR TO OR AT THE TIME OF ADMISSION

1. **Hittle House New Client Information Sheet**
2. **Copy of Medical Card**
3. **Copy of most recent assessments or evaluations**
4. **All parent, guardian, county and probation contact information (including but not limited to phone number, fax number, address and email address)**

THE INFORMATION LISTED ABOVE IS NEEDED TO COMPLETE OUR FILES. IF THERE ARE ANY QUESTIONS CONCERNING THIS INFORMATION, PLEASE CALL OUR OFFICE AT 614-443-5454 OR EMAIL MERCEDES ANDERSON AT mercedes@hittlehouse.com.

NEW CLIENT INFORMATION SHEET

Child's Name:________________________ **Age:**____________

DOB:____________ **DOA:**____________ **Grade:**____________

Parent/Guardian and Household Information

Parent/Guardian Name(s):________________________________

Address:____

Home Phone:____________________ **Cell Phone:**____________________

Email Address:____

Employer:____________________ **Occupation:**____________________

Name all the people who live with your child, their ages and their relationship to him:

____

____

____

Chief Concerns

Explain why your child was referred to treatment: ____________________

____

____

____

What are your child's personal strengths? ____________________

____

____

What are the three biggest concerns for your child?

1. ____

2. ____

3. ____

What are your goals for your child's treatment? What changes would you like to see?

____

____

____

Psychological History

Prior Mental Health Treatment (include dates) ______________________________

____

Is your child bothered by problems with sleep? ☐Yes ☐No

Please describe: ____

Is your child bothered by hearing or seeing things or by voices? ☐Yes ☐No

Please describe: ____

Please describe your child's eating patterns: ______________________________

Does your child have any toileting issues (i.e. bedwetting)? ______________________

Does your child have a history of running away or AWOL? ☐Yes ☐No

Does your child have a history of self-harm? ☐Yes ☐No

If so, please give the date of the last incident ______________________________

Does your child have a history of harming others? ☐Yes ☐No

If so, please give the date of the last incident ______________________________

Does your child have a history of fire setting? ☐Yes ☐No

If so, please give the date of the last incident ______________________________

Does your child have a history of cruelty to animals? ☐Yes ☐No

If so, please give the date of the last incident ______________________________

Please describe your child's sexual history to the best of your ability. Please include all abuse, offenses and consensual interactions ______________________________

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Psychiatric and Medication History

Is your child currently receiving any type of psychotherapy or counseling? ☐Yes ☐No

If yes, by whom? ____

Does your child have a history of mental health problems or hospitalizations? ☐Yes ☐No

If so, complete the following

Diagnosis	Dates Treated	By Whom

MEDICATIONS TAKEN PREVIOUSLY (if any)

Please check the box for each medication your child has tried in the past. Next to the name of the medication, please write the dose they were prescribed, how long they tried it and its effectiveness.

☐Prozac (fluoxetine)
☐Zoloft (sertraline)
☐Luvox (fluvoxamine)
☐Paxil (paroxetine)
☐Celexxa (citalopram)
☐Lexapro (escitalopram)
☐Effexor (venlafaxine)
☐Pristiq (desvenlafexine)
☐Cymbalta (duloxetine)
☐Wellbutrin (bupropion)
☐Desyrel (trazodone)
☐Remeron (mirtazapine)
☐Tegretol (carbamazepine)
☐Lithium
☐Depakote (valproate)
☐Lamictal (lamotrigine)
☐Topamax (topiramate)
☐Seroquel (quetiapine)
☐Risperdal (risperidone)
☐Zyprexa (olanzapine)
☐Geodon (ziprasidone)
☐Abilify (aripiprazole)
☐Tenex (guanfacine)
☐Vistaril (hydroxyzine)
☐Xanax (alprazolam)
☐Ativan (lorazepam)
☐Restoril (temazepam)
☐Klonopin (clonazepam)
☐Valium (diazepam)
☐Ambien (zolpidem)
☐Buspar (buspirone)
☐Adderall (amphetamine)
☐Concerta (methylphenidate)
☐Ritalin (methylphenidate)
☐Strattera (atomoxetine)
☐Vyvanse (lisdexamphetamine)
☐Focalin (dexmethylphenidate)
☐Daytrana Patch (methylphenidate patch)
☐Intuniv (guanfacine ER)
☐Clonidine
☐Neurontrin (gabapentin)
☐Emsam (selegiline patch)
☐Other Medications:

Please list current medications your child is taking:

Medicine	Dosage	Frequency	Prescribed By

____

____

Medical History

Allergies: ____

Has your child suffered from any significant medical illnesses? ☐Yes ☐No

If yes, please describe: ____

____

____

Current medical problems: ____

____

____

Past medical problems, hospitalizations and/or surgeries (please include dates):

____

____

____

Primary care provider: ____

Date and place of last physical: ____

Has your child ever had:

An EKG (heart)? ☐Yes ☐No

Please describe: ____

An MRI/PET/CT (brain scan)? ☐Yes ☐No

Please describe: ____

An EEG (monitor for seizures)? ☐Yes ☐No

Please describe: ____

CHECK IF YOUR CHILD HAS A HISTORY OF:

☐Anemia
☐Anxiety
☐Asthma
☐Attention Problems
☐Bipolar
☐Cancer
☐Depression
☐Dental Problems
☐Diabetes
☐Digestive Problems
☐Ear Infections
☐Feeding Problems
☐Heart Problems
☐Head Trauma
☐Panic Attacks

☐Psychosis	☐Strep Infections	☐Stomach Problems
☐Seizures	☐Speech Problems	☐Other:________

Substance Use

Has your child ever been treated for alcohol or drug abuse? ☐Yes ☐No

If yes, which substances: ____________________

If yes, where were they treated and when? ____________________

____

To your knowledge, has your child ever tried alcohol or other drugs? ☐Yes ☐No

Educational History

What school did your child previously attend? ____________________

What school district was your child enrolled in? ____________________

How are his grades? ____________________

Does your child have any identified learning disabilities? ☐Yes ☐No

If yes, please describe: ____________________

____

Is your child on an IEP? ☐Yes ☐No

How does your child do socially at school? ____________________

____

____

What are your child's best subjects? ____________________

____

What are your child's worst subjects? ____________________

____

What do your child's teachers say about him? ____________________

____

Developmental History

Was your child adopted? ☐Yes ☐No

When your child was born, were there any medical concerns during labor, delivery, or immediately after his birth? ☐Yes ☐No

If yes please describe: ____

____

____

Developmental milestones (sitting up, walking, talking, toilet training, etc.) were:

☐ On Time ☐ Delayed ☐ Earlier Than Other Children ☐ Not Sure

Please indicate any pertinent developmental issues (and please explain each):

0-1: ____

2-4: ____

5-12: ____

13-17: ____

Has your child experienced parental divorce? ☐Yes ☐No

If so, how old was your child? ____

If so, with whom does your child live? ____

Describe your child's relationship with you: ____

____

____

Describe your child's relationship with his other parent(s): ____

____

____

Describe your child's relationship with his siblings: ____

____

____

What, if any, are your child's responsibilities at home? ____

____

____

Family History

Does your child have any biological relative with any serious health problems? ☐Yes ☐No

If yes, please describe: ______________________________

____

Has any family member been treated with a psychiatric medication? ☐Yes ☐No

If yes, what medications, and how effective were they? ______________________________

____

____

To your knowledge, has any family member attempted suicide? ☐Yes ☐No

If yes, whom? ______________________________

Please list all biological relatives who have been diagnosed with the following conditions:

Depression: ______________ Anxiety: ______________

Anger: ______________ Violence: ______________

Alcohol Abuse: ______________ ADHD: ______________

Eating Disorder: ______________ Drug Abuse: ______________

Schizophrenia: ______________ Bipolar: ______________

Legal History

Has your child ever been arrested? ☐Yes ☐No

If yes, please explain: ______________________________

____

Does your child have any pending legal problems? ☐Yes ☐No

If yes, please explain: ______________________________

____

Trauma History

To your knowledge, was your child ever physically, verbally or sexually abused? ☐Yes ☐No

If so, please briefly describe: ______________________________

____

Has your child ever experienced the loss or death of a close loved one? ☐Yes ☐No

If so, please briefly describe: ______________________________

Recreation

What kind(s) of exercises does your child get?______________________________

In what after school activities does your child participate?________________________

____

Does your child play video games? ☐Yes ☐No

If so, which ones?____

How many hours per day?_____________ Hours per week:_____________

Does your child watch television? ☐Yes ☐No

How many hours per day?_____________ Hours per week:_____________

Does your child have a television or computer in his bedroom? ☐Yes ☐No

Does your child have his own cellphone? ☐Yes ☐No

How often does your child visit with friends? ________________________________

What do you think about your child's group of friends? __________________________

____

Spirituality

Does your family belong to a particular religion or spiritual group? ☐Yes ☐No

If yes, what is the level of your family's involvement? ___________________________

If your family does not belong to a group, does your family have any spiritual beliefs or life philosophy that is particularly important to you?

Please explain: ____

____

____

Other

Please tell us any other information that you believe may improve our ability to provide effectively care for your child: ____

____

____

Do you wish for us to coordinate with your child's other providers? ☐Yes ☐No

If yes, whom? ____